Correspondence

Sir,—We are grateful for the opportunity to reply to the letter from Drs Jones and Nixon, comparing the results of their audit of postoperative extradural analgesia with our own published results. It would appear from the results of Dr Jones and colleagues that the use of extradural fentanyl-bupivacaine mixture was associated with less hypotension and better pain relief than the diamorphine-bupivacaine mixture used in our audit. However, comparisons based on audit data from different institutions are difficult and we would like to make the following points: (1) the majority of our patients were more than 60 yr of age and were recovering from major upper abdominal surgery, thoracic surgery or chest trauma. There are no details on the case mix of Dr Jones’ patients; (2) the audit included data from our learning curve while setting up the service, whereas the group from Gwent ran a series of pilot studies and audited their definitive regimen.

Nevertheless, we would totally support their recommendations that extradural infusion analgesia can be managed in a general ward setting, under the supervision of an acute pain team, and that further research is necessary to determine the most appropriate opioid to use in combination with local anaesthetic drugs for extradural analgesia.

R. G. WHEATLEY  
T. H. MADEJ  
York District Hospital  
York

Neuromuscular block and tourniquets

Sir,—The problem with atracurium degradation in an isolated limb [1] has been noted before [2]. However, in the course of a study [3] of the effects of adding atracurium to a Bier’s block (atracurium 2 mg in 0.5 % prilocaine 40 ml), we showed that motor paralysis was always prolonged beyond the time of tourniquet deflation, in one case for nearly 1 h after a tourniquet time of 47 min.

It is difficult to explain the difference, although it may lie in our use of an Esmarch bandage to achieve maximal exsanguination. However, this does point the way to a reliable technique for paralysing an isolated limb, even with tourniquet.

P. H. P. HARRIS  
Derbyshire Royal Infirmary  
Derby

Spinal anaesthesia and aspirin

Sir,—Tinker warned in a book review [1] about “making unreferenced statements that, however innocuous they may seem to anesthesiologists, may prove problematic when used against us by lawyers”. A review in a postgraduate issue of British Journal of Anaesthesia may be seen as authoritative advice. In her review of problems with regional anaesthesia [2], Dr Macdonald stated, without supporting references, that patients receiving aspirin should be warned of the hazards of siting an extradural catheter. She prefaced her statement with “In some situations”: but what situations? The more widespread view is that aspirin is not an important risk, and that it is not necessary to explain it to the patient. The incidence of neurological complications was given by Dr Macdonald as less than 1 in 11000, and this incidence must include (if not be almost entirely) complications caused by direct nerve injury. There is much legal debate about whether or not complications of this rarity need be disclosed for normal informed consent, or even when patients question further [3].

However, as Wildsmith and McClure [4] pointed out, “there are no data, only opinions” on whether or not aspirin therapy increases the risk of spinal haematoma, and Dr Macdonald should have cited their earlier editorial [5]. If anaesthetists do not know the level of risk, we cannot explain it to our patients.

N. W. GOODMAN  
University of Bristol and Southmead Hospital  
Bristol


Sir,—Dr Goodman paraphrases out of context. I wrote, “even rare hazards may have to be explained, for example, risk of siting an extradural catheter in a patient on aspirin therapy” [1]. The preface “in some situations” should need no explanation to practising obstetric anaesthetists. The earlier editorial by Wildsmith and McClure [2] highlighted the problems of aspirin, measurement of bleeding time and risks of haematoma, and should have been cited by me. I apologize for that omission.

However, the capillaries and veins in the extraderal space of a pregnant woman in labour may be at more risk of damage than those of the non-pregnant patient at rest. Does this increase the risk of a possible haematoma in the presence of potential platelet dysfunction? The dilemma continues [3,4]. Paull states “the effect of aspirin on the incidence of post-epidural haematoma will join the growing list of unprovable hypotheses confronting modern medicine” [3]. Platelet dysfunction and the risk of siting an extradural catheter in the pregnant and labouring woman continue to be debated.

In the meantime, I would hope that my innocuous example would not prove problematic as “there are no data, only opinions” [5]. Is it not the duty of the judge, having listened to practising experts’ opinions, to decide?

R. MACDONALD  
Department of Postgraduate Medical Education  
University of Leeds  
Harrogate


